



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
Determination of Need Program  
250 Washington Street, Boston, MA 02108

DEVAL L. PATRICK  
GOVERNOR

Tel: 617-624-5690  
[www.mass.gov/dph/don](http://www.mass.gov/dph/don)

JOHN W. POLANOWICZ  
SECRETARY

September 17, 2014

CHERYL BARTLETT, RN  
COMMISSIONER

Dear Prospective Applicant:

Enclosed is the updated version of the Determination of Need ("DoN") Application Kit to be completed for original DoN applications involving substantial capital expenditure or substantial change in service. The DoN Application Kit is modified from time to time to reflect changes in the DoN review process resulting from changes to Massachusetts statutes (M.G.L. c.111, §§ 25B to 25G, §§ 51 through 53, 51A, and 71) and the DoN regulation (105 CMR 100.000). The latest revisions to the DoN regulation ([105 CMR 100.000](#)) went into effect on August 1, 2014. Please consult the regulation for detailed filing requirements. Note especially the section of the regulation listed below for DoN actions that do not use this application kit:

- Amendments to Approved DoN Projects – 105 CMR 100.750 et seq.
- Change of Ownership (Hospitals and Ambulatory Care Centers) – 105 CMR 100.600 et seq.
- Conversion of Acute Care Beds to Non-Acute - 105 CMR 100.604 et seq.
- Transfer of Ownership for Approved, Unimplemented Projects – 105 CMR 100.710
- Transfer of Site – 105 CMR 100.720

#### Preparation of Application

An application must be prepared in conformance with the DoN regulation and pertinent guidelines that are in effect at the time of filing as well as DoN policy advisories as may be posted from time to time on the DoN website. Every prospective applicant is strongly encouraged to consult with DoN Program staff during the preparation of an application.

#### DoN Guidelines

The DoN Program utilizes guidelines for analyzing need for the following regulated services:

- Acute Inpatient Rehabilitation Services
- Conversion of Acute Care Beds to Non-Acute Care Services
- Ambulatory Surgery
- Nursing Homes that are part of Continuing Care Retirement Communities
- Level IV Residential Care Facilities
- Long Term Care Facility Replacement and Renovation
- Magnetic Resonance Imaging
- Megavoltage Radiation Therapy
- Neonatal Intensive Care Units
- Positron Emission Tomography (PET)

If a project involves any of the categories listed above, an applicant should request the appropriate guidelines by contacting the DoN Program Office ([DPH.DoN@massmail.state.ma.us](mailto:DPH.DoN@massmail.state.ma.us) or 617-624-5690).

Any project involving new construction or gut renovation is subject to the DoN Guidelines for Environmental and Human Health Impact ("[Green Guidelines](#)").

Please note that, pursuant to 105 CMR 100.301 of the DoN Regulation, an application shall not be accepted for filing if the applicable DoN guidelines in effect at the time of filing indicate that no need exists for the service.

#### Factor 9: Community Health Initiatives

For information regarding completion of DoN Factor 9, applicants should review the memorandum on Community Health Initiatives posted on the DoN website [www.mass.gov/dph/don](http://www.mass.gov/dph/don).

#### Submission of Application

1. **Filing Dates** for DoN Applications, set forth at 105 CMR 100.302, were not changed in the August 2014 revisions of the regulation and are summarized as follows:
  - **First business days of February and August** - applications for establishment of services and devices from the list of [Innovative Services and New Technology](#).
  - **Any business day** – all other applications
2. **Application Fee.** Pursuant to a change to M.G.L. c. 111, §25C enacted in St. 2012, c. 224, (“Chapter 224”), the application fee for Determination of Need has changed. Effective August 1, 2014, the fee for applications involving substantial capital expenditure or substantial change in service is 0.2% (.002) of the total requested capital expenditure, or a minimum of \$250.00, whichever is greater.
3. **Application Format and Required Copies.** Applicants should note that all required copies of a DoN application may now be submitted to the appropriate state office by email in electronic PDF format. Only one original hard copy of the application is required to be submitted to the DoN Program in addition to one copy in PDF format.

Contact information for each agency, division or office where a copy of the application is required to be submitted may be found at

<http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/ohp/don/apply/applications.html>.

A copy of an application is only required to be submitted to Department of Mental Health and Executive Office of Elder Affairs if the proposed project involves mental health services or long term care, respectively. Chapter 224 added the requirement that a copy of all DoN applications be submitted to the Health Policy Commission.

Please contact a DoN staff member for guidance and advice in the preparation of an application. Our contact information is as follows:

Telephone: 617-624-5690  
Email: DPH.DoN@massmail.state.ma.us

Sincerely,



Bernard Plovnick, Director  
Determination of Need Program

TO: Prospective Applicants for  
Long Term Care Projects

FROM: Determination of Need Program Director

DATE: March 16, 2004  
(Updated August 27, 2013)

SUBJECT: Special Instructions for Completion of the  
Determination of Need Application Kit

Long Term Care applicants should complete the entire application kit, with the following changes or additions:  
(see also May 25, 1993 Determination of Need Guidelines for Nursing Facility Replacement and Renovation).

FACTOR 3 (Operational Objectives – see also May 25, 1993 Nursing Facility Replacement and Renovation Guidelines)

3.4 - Nursing Home DoN applicants should state: (1) their plans for referring applicants for admission who may be appropriate for acute care services or home care services, and (2) their plans for coordination of services with the appropriate home care corporation, including planning for residents who are appropriate candidates for discharge into the community.

NOTE: Home Care Corporations are independent corporations charged with the responsibility of carrying out the Home Care Program of the Executive Office of Elder Affairs. Each Home Care Corporation provides or arranges home care for residents in the service area of the corporation. Home care services are designed to assist elders in maintaining independent living within their home environment.

If in doubt, an applicant for DoN should contact the Executive Office of Elder Affairs to determine which Home Care Corporation serving the geographic region of the service area of the proposed facility. The general information number at the Executive Office of Elder Affairs is 1-617-727-7750.

FACTOR 4 (Standards Compliance):

Applicants should review the general standards of construction for a long-term care facility (105 CMR 150.000) which is available at <http://www.mass.gov/eohhs/docs/dph/regs/105cmr150.pdf> or at the State House Bookstore (617-727-2834).

FACTOR 5 (Reasonableness of Expenditures and Costs):

Complete schedules A, C, D, E, F, F1, F2, G, and H. Schedule H should be completed by level of care. Substitute “Level of Care” for “Service” wherever the term appears.

FACTOR 6. (Financial Feasibility and Capability)

- Applicants are advised to review the Center for Health Information and Analysis regulations at 114.2 CMR 6.00 to determine the actual payment to providers for MassHealth (Medicaid) residents.
- Applicants should consult the DoN staff for the latest standards on cost per gross square footage, major movable equipment, and pre- and post- planning costs.
- Applications involving Life Safety Code renovations should include copies of survey reports.

FACTOR 8 (Environmental Impact)

Applications involving new construction or gut renovation should consult the Determination of Need Guidelines for Environmental and Human Health Impact.

# **MASSACHUSETTS DETERMINATION OF NEED APPLICATION KIT**

**September 2014 Revision**

**Determination of Need Program  
250 Washington Street  
Boston, MA 02108**

## INTRODUCTION

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The purpose of the Massachusetts Determination of Need Application Kit is twofold. First, it is to provide applicants with a clear indication of the nature, scope and depth of preparations expected of them. Second, it is to provide DoN Program staff, as well as the Public Health Council, with the information necessary for fair and thorough evaluations. The kit should contribute to the speed, consistency, and predictability of reviews while increasing public involvement.

It should be noted that many of the questions presented in this kit are organized according to the factors found in 105 CMR 100.533. The questions listed under individual factors in the kit are intended to assist applicants and reviewers by gathering relevant information in a structured and convenient manner. Although questions are grouped by factors, the completed application will be viewed and evaluated in its entirety. Questions have been categorized in order to avoid unnecessary repetition of data requests rather than to limit the use of specific information to the evaluation of any particular factor or factors.

Since no general kit can be exhaustive in its data requests, it will remain the responsibility of applicants to provide all necessary information. Currently, it is often necessary for reviewers to request information not supplied in an applicant's original submission. Use of this kit is expected to substantially reduce, although not eliminate, the need for additional data requests. Statutory and regulatory changes may take place from time to time and may not be reflected in this kit. It is the duty of the applicant to be cognizant of such changes and to file an application consonant with such changes.

Updated September 2014

## GENERAL INSTRUCTIONS

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Enclosed is an application form for Determination of Need. In order to complete this form, it is necessary to read and comply with the Massachusetts Determination of Need Regulation 105 CMR 100.000. An unofficial version of the regulation may be found online at the DoN website ([www.mass.gov/dph/don](http://www.mass.gov/dph/don)) or the official version may be obtained from the State House Bookstore, Boston, MA 02133, Telephone: (617) 727-2834 (<http://www.sec.state.ma.us/spr/sprcat/catidx.htm>).

Assistance in preparing applications is available from the Determination of Need Staff (617-624-5690).

### CONTENTS OF APPLICATION

Please refer to 105 CMR 100.300-100.303 and 105 CMR 100.320-100.326 regarding the required contents of the application.

Please note that 105 CMR 100.350-100.354 substantially limits the right of applicants to alter applications or to provide additional information after an application has been submitted. Therefore, applicants should not file an application unless and until all important information is included.

Please note that if a filing fee is required (See 105 CMR 100.323) it must be submitted with the application, by check, payable to the **"Commonwealth of Massachusetts."**

Please see 105 CMR 100.306 which requires documentation as to ownership and zoning. Such documentation need only be submitted with the original copy and referenced in succeeding copies.

Newspaper Notice: Every applicant for Determination of Need is required to publish a notice of application, as prescribed in 105 CMR 100.330-100.332, in the legal notice section of the appropriate newspaper and an identical notice at least once in some other section as well. Refer to the regulation for details of publication. Please note that the final day to request a public hearing or to register as a ten taxpayer group (following the publication) must be on a business day. Please attach a true copy of the notices of publication with date of publication, as required under the above-referenced section, immediately after page 3 of general instructions.

No application will be accepted if the requirements of 105 CMR 100.306 and 100.320-100.326 are not met, and no application will be accepted if all relevant parts of the application kit are not complete.

PLEASE NOTE: The Determination of Need application kit asks applicants, in some cases, to supply answers on additional sheets. Where additional sheets are used, they should be clearly labeled with the factor name, question number (and page number) to which they pertain.

## GENERAL INSTRUCTIONS

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### DISTRIBUTION OF COPIES

(105 CMR 100.300) Applicants must submit one complete original hard copy and one electronic copy in PDF format (or one original and two additional hard copies) to:

Department of Public Health  
Determination of Need Program  
250 Washington Street  
Boston, MA 02108  
[Dph.don@massmail.state.ma.us](mailto:Dph.don@massmail.state.ma.us)

Applicants must also submit one hard copy (or electronic copy in PDF format) to the offices listed below. An updated list of contact persons with phone numbers and email addresses is available at the DoN website ([www.mass.gov/dph/don](http://www.mass.gov/dph/don)) in the “Applications” section.

Department of Public Health  
Regional Health Office  
(See 100.300 for appropriate office)

*If relevant under Section 100.152:*

Executive Office of Elder Affairs  
One Ashburton Place, 5th Floor  
Boston, MA 02108

Center for Health Information and  
Analysis  
Two Boylston Street  
Boston, MA 02116

*If relevant under Section 100.153:*

Division of Medical Assistance  
Office of Acute and Ambulatory Care  
100 Hancock Street  
Quincy, MA 02171

Department of Mental Health  
Division of Clinical & Professional Services/  
Office of Policy Development  
25 Staniford Street  
Boston, MA 02114

Health Policy Commission  
2 Boylston Street, 6th Floor  
Boston, MA 02116

MassHealth  
1 Ashburton Place  
Boston, MA 02108

### FILING FEE AND COMPUTATION SHEET

Every applicant, other than a government agency, filing under M.G.L. c. 111, §25C is required to accompany the application with a filing fee as indicated below:

MAXIMUM CAPITAL EXPENDITURE: \$\_\_\_\_\_ x .0020  
= \$\_\_\_\_\_ Filing Fee

Minimum Filing Fee is \$250.00, regardless of maximum capital expenditure.

Applicant must attach a check or money order made payable to the “**Commonwealth of Massachusetts**” in the amount indicated above. If applicant claims an exemption from the filing fee, state here why the applicant is exempt, citing the applicable section of the regulation.

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## DON APPLICATION FACE SHEET

- 1a. FILING DATE: \_\_\_\_\_ 1b. FILING FEE: \$ \_\_\_\_\_
2. HSA: \_\_\_\_\_ 3. ☐ REGULAR or ☐ UNIQUE APPLICATION (Check one)
4. APPLICANT NAME: \_\_\_\_\_
5. ADDRESS: \_\_\_\_\_
6. CONTACT PERSON: (Name) \_\_\_\_\_ (Title) \_\_\_\_\_  
 (Mailing Address): \_\_\_\_\_ (Telephone) \_\_\_\_\_  
 Email: \_\_\_\_\_
- 7a. FACILITY NAME: \_\_\_\_\_
- 7b. LOCATION: \_\_\_\_\_
8. FACILITY TYPE (circle one):  
 1) Acute Care Hospital      2) Nursing Facility      3) Ambulatory Surgery Center  
 4) Chronic Disease/Rehabilitation Hospital    5) Other \_\_\_\_\_
9. TYPE OF OWNERSHIP (circle as appropriate):  
 1) Private non-profit      3) Public  
 2) Private for-profit      4) Other \_\_\_\_\_
10. BRIEF PROJECT DESCRIPTION (consistent with newspaper notice):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
11. PROJECT TYPE (check one or more as appropriate):
- ☐ **Substantial Change in Service** – The addition or expansion of or conversion to a new technology, innovative service, or ambulatory surgery by acute care or non-acute care facilities regardless of whether the expenditure minimum is exceeded; non-acute care services provided by acute care hospitals; and any increase in bed capacity by a non-acute care facility totaling more than 12 beds to the licensed bed capacity of the entire facility.
  - ☐ **Substantial Capital Expenditure** – Any capital expenditure that is at or exceeds the DoN expenditure minimums for acute care, non-acute care (including nursing homes) facilities and clinics.
  - ☐ **Original Licensure** – Original licensure of hospitals or clinics providing ambulatory surgery. This includes an original license to be issued following a transfer of ownership.



## DON APPLICATION FACE SHEET

12. BEDS INVOLVED IN THE PROJECT (select all that apply):

	Existing Number of Licensed Beds	Number of Additional Beds Requested	Number of Beds Replaced/Renovated
<b>Acute</b>			
Medical/Surgical			
Obstetrics (Maternity)			
Pediatrics			
Neonatal Intensive Care			
ICU/CCU/SICU			
<b>Acute Rehabilitation</b>			
<b>Acute Psychiatric</b>			
adult			
adolescent			
pediatric			
<b>Chronic Disease</b>			
<b>Substance Abuse</b>			
detoxification			
short-term intensive rehabilitation			
<b>Skilled Nursing Facility</b>			
Level II			
Level III			
Level IV			
<b>Other</b> (specify)			

13. MAXIMUM CAPITAL EXPENDITURE: \$ \_\_\_\_\_

14. ANNUAL INCREMENTAL OPERATING COST: \$ \_\_\_\_\_

15. COMMUNITY HEALTH SERVICES INITIATIVES EXPENDITURE (see Factor 9)

\$ \_\_\_\_\_

(Address of Applicant, Street, City/Town and Zip Code)

: \_\_\_\_\_ original licensure  
 \_\_\_\_\_ substantial capital expenditure  
 \_\_\_\_\_ substantial change in service

With respect to a: \_\_\_\_\_ hospital  
 \_\_\_\_\_ long term care facility  
 \_\_\_\_\_ ambulatory surgery center  
 \_\_\_\_\_ other (specify) \_\_\_\_\_

for the development of: \_\_\_\_\_  
(Name of facility and/or program)

at the following address: \_\_\_\_\_  
(Street, City/Town and Zip Code)

City \_\_\_\_\_ State \_\_\_\_\_  
County \_\_\_\_\_ Private Nonprofit Organization \_\_\_\_\_

Proprietary: \_\_\_\_\_ Individual Corporation \_\_\_\_\_ Partnership

\$\_\_\_\_\_.

\*All persons participating in joint venture DoN applications (e.g., applications with two or more corporations) should be aware that each person who comprises the "applicant" will have to be named on the license. In addition, any subsequent changes in ownership of any person comprising the licensee will require compliance with the relevant change of ownership procedures.

All joint venture applicants should carefully evaluate the effect these requirements will have on their future activities.

1. I have read 105 CMR 100.000, the Massachusetts Determination of Need Regulation.
2. I have read this application for Determination of Need including all exhibits and attachments, and the information contained therein is accurate and true.
3. I have submitted the required copies of this application to the Determination of Need Program and to all relevant agencies (see below\*) as required.
4. I have caused notices to be published as required by 105 CMR 100.330-100.332. The notices, true copies of which are enclosed, were published in the

\_\_\_\_\_ on \_\_\_\_\_  
(Name of Newspaper) (Date of Publication)

Signed on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, under the pains and penalties of perjury.

For Corporation: \_\_\_\_\_ and \_\_\_\_\_  
 Chief Executive Officer Chairman of the Board

Partnership: \_\_\_\_\_  
All Partners

Limited Partnership: \_\_\_\_\_  
General Partner

Trust: \_\_\_\_\_  
All Trustees

Copies of this application have been submitted as follows:

- ☐ Executive Office of Elder Affairs\*
- ☐ Regional Health Office
- ☐ Department of Mental Health\*\*
- ☐ Division of Medical Assistance
- ☐ Health Policy Commission
- ☐ Center for Health Information and Analysis
- ☐ MassHealth

\*Only if the project relates to long term care

\*\*Only if project relates to mental health

## GENERAL INSTRUCTIONS

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1. List all officers, members of the board of directors, trustees, stockholders, partners, and any other individuals who have an equity or otherwise controlling interest in the application. With respect to each of these persons, please give his or her address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of, partnership or other equity interest. (Answer on additional sheet).
2. Have any of the individuals listed ever been convicted of any felony or ever been found in violation of any local, state or federal statute, regulation, ordinance, or other law which arises from or otherwise relates to that individual's relationship to a health care facility?
3. For all individuals listed, list all other health care facilities, within or without the Commonwealth in which they are officers, directors, trustees, stockholders, partners, or in which they hold an equity interest.
4. State whether any of these individuals presently have, or intend to have, any business relationship, including but not limited to: supply company, mortgage company, etc., with the applicant.
5. If the applicant is a corporation, please attach a copy of your articles of incorporation to this section of your application.
6. Indicate here the applicant's representative in regard to this application:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Title

\_\_\_\_\_  
Email

\_\_\_\_\_  
Facility/ Organization

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Address (Street, Town/City, and Zip Code)

All written and oral communications will be directed accordingly.

## **APPLICATION NARRATIVE (PROJECT SUMMARY)**

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Please describe *briefly* the proposed project in the space indicated below. Detailed information is requested elsewhere in the application under “Factors Applied in Determination of Need.” All applicants are required to provide an application narrative.

# **FACTORS APPLIED IN DETERMINATIONS OF NEED**

**Factor 1                    HEALTH PLANNING PROCESS**

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1.1        Please provide a brief description of the annual planning process used by your institution, including the decision to undertake the proposed project. (Answer on a separate sheet)

1.2        Did you consult with other providers in the primary service area of this project about the relationship of this project to existing or planned operations at their institutions?

             YES\_\_\_\_\_                    NO\_\_\_\_\_

1.2a       If your answer to question 1.2 was "NO", please explain below why you did not consult with other providers.

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1.2b. If your answer to question 1.2 was "YES", please supply the name and titles of persons with whom you consulted and results of the consultation. (use separate sheet if necessary)

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## Factor 1 HEALTH PLANNING PROCESS

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- 1.3 Since a broad range of inputs is valuable in the planning of a project, applicants are encouraged to undertake a diverse consultative process. Please indicate which, if any, of the following agencies or groups you consulted in the development of this application.

Determination of Need Program (DPH) YES \_\_\_\_\_ NO \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Department of Mental Health YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_  
(for mental health projects)

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Executive Office of Elder Affairs YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_  
(for projects with special significance for elders)

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

EOHHS Office of Acute and Ambulatory Care YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_

Date (s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Other Relevant Agencies or Parties YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_

Name (s) \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Name (s) \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_



## Factor 2                    HEALTH CARE REQUIREMENTS

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- 2.1     How will this project affect accessibility of services for the prospective patients who are poor, medically indigent and/or Medicaid eligible?

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- 2.2     Describe below and on additional sheet(s) your need analysis for this project including any special conditions for consideration. If your analysis is inconsistent with the relevant need methodology or criteria of Determination of Need Guidelines, please explain on the additional sheet(s) why you believe your methodology is more appropriate. Long-term care applications should show how they meet the criteria for bed replacement and/or substantial renovation of beds or the facility, consistent with the *May 25, 1993 Determination of Need Guidelines for Nursing Facility Replacement and Renovation*.

## Factor 2 HEALTH CARE REQUIREMENTS

### 2.3: Statistical Data--Routine Inpatient Services

Complete only for those routine inpatient cost centers, as specified by the *Hospital Uniform Reporting Manual*\*\*, in which you are requesting a change.

	(1)	(2)	(3)	(4)	(5)	(6)
	Cost Center	Licensed Weighted Average Bed Capacity	Occupancy Rate	Average Length of Stay	Number of Discharges	Number of Patient Days
1						
2	20 Actual (A)					
3	20 (A)					
4	20 (A)					
5						
6	20 (P <sub>1</sub> )*					
7	20 (P <sub>1</sub> )					
8	20 (P <sub>1</sub> )					
9	20 (P <sub>1</sub> )					
10						
11	20 (P <sub>2</sub> )*					
12	20 (P <sub>2</sub> )					
13	20 (P <sub>2</sub> )					
14	20 (P <sub>2</sub> )					
15						
16						
17	20 Actual (A)					
18	20 (A)					
19	20 (A)					
20						
21	20 (P <sub>1</sub> )*					
22	20 (P <sub>1</sub> )					
23	20 (P <sub>1</sub> )					
24	20 (P <sub>1</sub> )					
25						
26	20 (P <sub>2</sub> )*					
27	20 (P <sub>2</sub> )					
28	20 (P <sub>2</sub> )					
29	20 (P <sub>2</sub> )					
30						
31						
32	20 Actual (A)					
33	20 (A)					
34	20 (A)					
35						
36	20 (P <sub>1</sub> )*					
37	20 (P <sub>1</sub> )					
38	20 (P <sub>1</sub> )					
39	20 (P <sub>1</sub> )					
40						
41	20 (P <sub>2</sub> )*					
42	20 (P <sub>2</sub> )					
43	20 (P <sub>2</sub> )					
44	20 (P <sub>2</sub> )					

\*Note: P<sub>1</sub> assumes project is approved and P<sub>2</sub> assumes project is denied.

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

## Factor 2 HEALTH CARE REQUIREMENTS

### 2.4: Statistical Data--Routine Inpatient Services

Complete only for those routine inpatient cost centers, as specified by the Division of Health Care Finance and Policy Uniform Reporting Manual\*\*, in which you are requesting a change.

	(1)	(2)	(3)	(4)	(5)	(6)
	Cost Center	Licensed Weighted Average Bed Capacity	Occupancy Rate	Average Length of Stay	Number of Discharges	Number of Patient Days
1						
2	20 Actual (A)					
3	20 (A)					
4	20 (A)					
5						
6	20 (P <sub>1</sub> )*					
7	20 (P <sub>1</sub> )					
8	20 (P <sub>1</sub> )					
9	20 (P <sub>1</sub> )					
10						
11	20 (P <sub>2</sub> )*					
12	20 (P <sub>2</sub> )					
13	20 (P <sub>2</sub> )					
14	20 (P <sub>2</sub> )					
15						
16						
17	20 Actual (A)					
18	20 (A)					
19	20 (A)					
20						
21	20 (P <sub>1</sub> )*					
22	20 (P <sub>1</sub> )					
23	20 (P <sub>1</sub> )					
24	20 (P <sub>1</sub> )					
25						
26	20 (P <sub>2</sub> )*					
27	20 (P <sub>2</sub> )					
28	20 (P <sub>2</sub> )					
29	20 (P <sub>2</sub> )					
30						
31						
32	20 Actual (A)					
33	20 (A)					
34	20 (A)					
35						
36	20 (P <sub>1</sub> )*					
37	20 (P <sub>1</sub> )					
38	20 (P <sub>1</sub> )					
39	20 (P <sub>1</sub> )					
40						
41	20 (P <sub>2</sub> )*					
42	20 (P <sub>2</sub> )					
43	20 (P <sub>2</sub> )					
44	20 (P <sub>2</sub> )					

\*Note: P1 assumes project is approved and P2 assumes project is denied.

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

## Factor 2 HEALTH CARE REQUIREMENTS

### 2.5: Statistical Data--Major Ancillary Services

Complete only for those routine inpatient cost centers, as specified by the *Hospital Uniform Reporting Manual*<sup>\*\*</sup>, in which you are requesting a change.

	(1) Service	(2) Standard Units of Measure	
1	<b>Surgical Services</b>	*	
2	20 Actual (A)		
3	20 (A)		
4	20 (A)		
5			
6	20 (P <sub>1</sub> )*		
7	20 (P <sub>1</sub> )		
8	20 (P <sub>1</sub> )		
9	20 (P <sub>1</sub> )		
10			
11	20 (P <sub>2</sub> )*		
12	20 (P <sub>2</sub> )		
13	20 (P <sub>2</sub> )		
14	20 (P <sub>2</sub> )		
15			
16	<b>Radiology Diagnostic</b>	*	
17	20 Actual (A)		
18	20 (A)		
19	20 (A)		
20			
21	20 (P <sub>1</sub> )*		
22	20 (P <sub>1</sub> )		
23	20 (P <sub>1</sub> )		
24	20 (P <sub>1</sub> )		
25			
26	20 (P <sub>2</sub> )*		
27	20 (P <sub>2</sub> )		
28	20 (P <sub>2</sub> )		
29	20 (P <sub>2</sub> )		
30			
31	<b>Laboratory</b>		
32	20 Actual (A)		
33	20 (A)	*	
34	20 (A)		
35			
36	20 (P <sub>1</sub> )*		
37	20 (P <sub>1</sub> )		
38	20 (P <sub>1</sub> )		
39	20 (P <sub>1</sub> )		
40			
41	20 (P <sub>2</sub> )*		
42	20 (P <sub>2</sub> )		
43	20 (P <sub>2</sub> )		
44	20 (P <sub>2</sub> )		

\* On this line, column 2, state the standard unit of measure as specified by the *Hospital Uniform Reporting Manual*. Note: Use copies of this sheet as needed.

<sup>\*\*</sup>Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

### Factor 3                      OPERATIONAL OBJECTIVES

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3.1      If this application proposes establishment of a new health service at your institution, do you have evidence of the clinical effectiveness of this new service? Please provide relevant documentation.

3.2      Briefly describe quality assurance mechanisms that will be used to assess the appropriateness of the health service proposed in this project.

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3.3      Does your institution have written referral arrangements pertaining to services covered in this application with other health care providers in the primary service area of this project? (Nursing and rest homes' applicants should have an agreement with at least one acute care hospital and one home health organization).

YES      \_\_\_\_\_(Please give brief descriptions of these referral arrangements)

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NO      \_\_\_\_\_(Please explain why you do not have referral arrangements)

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Note: In addition to the above measures, all projects must meet the operational objectives of relevant service-specific guidelines.

## **Factor 4                      STANDARDS COMPLIANCE**

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If this project involves renovation or new construction, please submit schematic line drawings for that construction.

Please consult the Determination of Need Program staff if you require guidance in completion of this section.

See "Square Footage" under DEFINITIONS, FACTOR 5.

## Factor 5 REASONABLENESS OF EXPENDITURES & COSTS

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### Definitions

#### 1. Capital Expenditure

Cost of the project expressed in a dollar amount as of the filing date (i.e., assuming the project were to commence on the filing date). (See discussion in Factor 6, Schedule D.)

#### 2. Functional Areas

Unit of space directly related to a particular service (e.g., nursing unit, laboratory, radiology, dietary and admissions) or a space common to the operation of the entire facility (e.g., lobby, mechanical, major circulation, exterior wall).

#### 3. Square Footage

**Net Square Feet (NSF):** The space associated with a particular department. It includes all functional space within a department; e.g., the interior of exam rooms, closets, utility rooms and waiting areas. Also, toilet rooms, walk-in refrigerators, and storage areas should be included if they are specifically for that department. It does not include allowances for internal partitions, departmental circulation, major circulation, shafts, ductways, general mechanical space and exterior walls.

**Gross Square Feet (GSF):** Includes the NSF of a Department plus circulation within the department, partitions within the department, and dedicated mechanical space (e.g., pump room for a surgical suite). The GSF for a specific functional department excludes major general mechanical space, ductwork, elevator shafts, and stairwells located within the department's boundaries; these components should instead be assigned to the GSF of a non-departmental- functional area such as "Elevators and Shafts," if they are significant.

If a department's perimeter is an interior wall, half of the thickness of the wall is allocated to the department. If the perimeter is an exterior wall, only 3 inches (i.e., half of a standard partition) of that wall's thickness is assigned to the department; the remainder belongs to the functional area "Exterior Wall."

Using these definitions, a facility's overall GSF is the sum total of the GSF of each functional area; that is, the total of the departmental GSF figures plus the area allocated to Major Circulation and Exterior Walls (i.e., the non-departmental areas.)

#### 4. Cost per Gross Square Footage

In calculating the cost/GSF, the DoN Program adds construction contract, fixed equipment not in contract, site survey and soil investigation, and architectural and engineering costs and divide by the proposed gross square footage. However, the specific costs for these components should be included separately in Schedule D.

## Schedule 5.1: Square Footage and Cost Per Square Foot

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
		Present Square Footage		Square Footage Involved in Project			
	Functional Areas	Net <sup>a</sup>	Gross <sup>a</sup>	New Construction Net	Gross	Renovation Net Gross	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40	Total						

<sup>a</sup> See the definitions on page 23.



## Schedule 5.1: Square Footage and Cost per Square Footage

		(8)	(9)	(10)	(11)	(12)	(13)
		Resulting Square Footage <sup>a</sup>		Total Cost		Cost/Square Footage	
	Functional Areas	Net	Gross	New Construction	Renovation	New Construction	Renovation
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40	Total			\$	\$		

<sup>a</sup> Column 8 does not necessarily equal Columns 4 plus 6 or Columns 2 plus 4 plus 6; Column 9 does not necessarily equal Columns 5 plus 7 or Columns 3 plus 5 plus 7. This is because, for example, a) there may be demolition and b) department A may be reassigned to department B.

<sup>b</sup> If this does not equal the sum of Lines 3,9,10 and 11 of Schedule D, please reconcile the difference (for example, do the costs include site survey and soil investigation, fixed equipment not in contract, and architectural and engineering costs which are not figured into Line 9 of Schedule D)

## Schedule 5.2 PROJECT IMPLEMENTATION

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### 6.2 Anticipated Project Schedule

Construction/ Renovation or  
Installation

Start Date

Completion Date

- Phase One
- Phase Two
- Phase Three
- Phase Four
- Etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Operations

Start Date

Reach Normal Volume

- Phase One
- Phase Two
- Phase Three
- Phase Four

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please *briefly* describe the phrases cited above:

Phase One \_\_\_\_\_

Phase Two \_\_\_\_\_

Phase Three \_\_\_\_\_

Phase Four \_\_\_\_\_

### 6.3 If you have not already provided a listing and description of the equipment requirements (if any) of this project please do so in the space below or on an additional sheet.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 6.4 Do you have any additional information, which you would like to supply concerning the reasonableness of the expenditures and costs associated with this project?

YES \_\_\_\_\_ NO \_\_\_\_\_

If "YES", please supply this information on an additional sheet or sheets.

## Factor 6                      FINANCIAL FEASIBILITY

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### LIST OF SCHEDULES FOR FACTOR SIX

SCHEDULE A:	Statement of Revenues and Expenses
*SCHEDULE B:	Statistical/Financial Data - Revenue Producing Cost Centers
SCHEDULE C:	Staffing Patterns
SCHEDULE D:	Estimated Capital Expenditure
SCHEDULE E:	Depreciation Expense
SCHEDULE F:	Proposed Funds for Estimated Capital Expenditure
SCHEDULE F1:	Features of Permanent Financing of Estimated Capital Expenditure
SCHEDULE F2:	Application of Permanent Financing Proceeds
SCHEDULE G:	Fixed Charges Covered
SCHEDULE H:	Revenue by Payer

The purpose of “Factor Six - Financial Feasibility” of the DoN Application is to: (1) collect evidence regarding the ability of the applicant to finance and support the operation of the proposed project; and (2) highlight the probable effects of the project, in cost and statistical terms.

It may be useful as a conceptual aid to think of the schedules that comprise “Factor Six- Financial Feasibility” as sorting into these categories:

- 1) Schedules A-C - information about the likely impact of the proposed project on operations of the applicant (institution).
- 2) Schedules D-G - information about the capital cost and the method of financing for the proposed project; and
- 3) Schedule H - information about the applicant's recent payer mix.

The schedules request the most recent annual historical data plus two sets of three-year projections for single service projects and the most recent three years historical data plus two sets of four-year projections for capital expenditure projects. “P1” is the projection of the likely future course of operations, assuming the project under consideration is approved by the Department. “P2” is the projection of the likely future course of operations, assuming the project under consideration is not approved by the Department.

The first projection year should be the first year following the last actual. The second, third, or fourth year projection should be the point in time when the project reaches normal volume.

The applicant must clearly explain its assumptions about costs (both operating and capital) on separate sheets to be attached to Schedule A.

## Factor 6 FINANCIAL FEASIBILITY

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Consistency is a key to the fairness and usability of “Factor Six- Financial Feasibility.” If assumptions about unit costs, occupancies, or similar items differ between P1 and P2, explain the reasons for these differences on separate sheets. Since it is obvious that the approval or denial of this application will not alter demographic or economic trends in the applicant’s area, it is expected that assumptions for P1 and P2 will be uniform for these items. This section uses Schedule A, the operating statement, to link the various other schedules together. This interlocking system will ensure that all comparisons of P1 and P2 will be made using consistent data, which fit smoothly into the broader financial situation of the applicant.

In order to obtain forecasts or financial and statistical impacts, it is necessary to consider the interrelationship of determination of need projects filed by an individual applicant. Therefore, if the applicant’s institution has more than one DoN application pending, or expects to file additional applications within one year of the date of this application, please note the application numbers and dates of the pending applications and the nature and scope of expected applications on the “assumptions” sheet attached to Schedule A. “P1” and “P2” projections must assume approval of all pending (rather than anticipated or expected) DoN applications. For example, an institution that has one application pending consideration, by the Department, and which is now filing another application, should:

- note the first application in the assumption section of Schedule A of the new application; and
- assume approval of the first application in both the “P1” and “P2” projections of the new application.

The new application should, in effect, show the combined projections if the first application were, in fact, to be implemented on the applicant’s proposed schedule.

On some schedules, hospitals are required to report financial and statistical data according to the specifications of the *Hospital Uniform Reporting Manual*.\*\* Of course, this requirement does not apply to non-hospital applicants.

These schedules will provide necessary information about the probable impacts of determination of need actions on individual applicants. Schedules A, G, and H should be completed for the whole facility and not only for the project’s revenue producing cost center(s).

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

## Factor 6                      FINANCIAL FEASIBILITY

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### Notes:

1. The financial and statistical information requested in Factor Six must be submitted on the schedules provided or on copies thereof.
2. Copies of audited financial statements for the most recent year must be filed with this application.
3. Assumptions used in projecting capital and operating costs, revenues, and demographic factors must be clearly explained on a separate sheet attached to the beginning of Factor 6.
4. Statistical data and projections provided in Factor Two are important for the Factor Six data and projections. Please review both Factor Two and Factor Six carefully to ensure overall consistency between them.
5. It is permissible to round dollar amounts to the nearest thousand, as long as such rounding does not materially affect the results. If you do so, please clearly indicate this on each page on which such rounding is done.
- 6(a) Use constant dollars for the projection years (that is, do not include inflation). Do not restate actual dollars.
- 6(b) In general, use the last complete fiscal year as the basis for constant dollars (e.g., an applicant filing May 2014 with a fiscal year ending September 2014 would state project costs in 2014 dollars).

## Schedule A: Statement of Revenues and Expenses

The data presented here must tie to later schedules and **should be for the entire institution and not only for the project's cost center.** Explain all variances. Should your institution have another application pending (i.e. accepted and under review by the Determination of Need Program), the projections made in these schedules must assume *approval* of all pending applications.

	(1)	(2)	(3)	(4)
		Actual 20__	Actual 20__	Actual 20__
1	Gross Patient Service Revenue*			
2	Less: Contractuals			
3	Provision for Doubtful Accounts			
4	Free Care			
5	Other (Specify)			
6	Net Patient Service Revenue			
7				
8	Other Operating Revenue*			
9				
10	Net Operating Revenue			
11				
12	Operating Expenses			
13a	Salaries, Wages* and Fringe Benefits (Exclude Pension)*			
13b	Purchased Services			
14	Supplies and Other Expenses			
15	Depreciation			
16	Interest			
17	Pension			
18				
19	Total Operating Expenses*			
20				
21	Gain (Loss) from Operations			
22				
23	Total Non-operating Revenue			
24				
25	Excess of Revenues Over Expenses			
26				
27				
28				
29				
30				

Note: For a single service project, complete the most recent year actual data and for a capital expenditure project by a hospital complete the most recent three years actual data.

## Schedule A: Statement of Revenues and Expenses

	(5)	(6)	(7)	(8)	(9)	(10)	(11)
		Assuming Project Approval			Assuming Project Denial		
		Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P2)	Projection 20____(P2)	Projection 20____(P2)
1	Gross Patient Service Revenue*						
2	Less: Contractuals						
3	Provision for Doubtful Accounts						
4	Free Care						
5	Other (Specify)						
6	Net Patient Service Revenue						
7							
8	Other Operating Revenue*						
9							
10	Net Operating Revenue						
11							
12	Operating Expenses						
13 a	Salaries, Wages* and Fringe Benefits (Exclude Pension)*						
13 b	Purchased Services						
14	Supplies and Other Expenses						
15	Depreciation						
16	Interest						
17	Pension						
18							
19	Total Operating Expenses*						
20							
21	Gain (Loss) from Operations						
22							
23	Total Non-operating Revenue						
24							
25	Excess of Revenues Over Expenses						
26							
27							
28							
29							
30							

\*For each of these items state on a separate and attached sheet the assumptions you made in arriving at P1 (assuming project approval, columns 5-8) and P2 (assuming project denial, columns 9-12) figures.

## Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

Complete in detail for each revenue producing cost center affected by the project. Data for revenue-producing cost centers not affected by the project should be presented in aggregate under "Other Revenue-Producing Cost Centers". Under Other it is expected that P1 and P2 will be identical. The cost centers and standard units of measure must be those required by *Hospital Uniform Reporting Manual*.

<http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>

	(1)	(2)	(3)	(4)
	Cost Center	Standard Unit of Measure	Gross Patient Service Revenue	Major Movable Equipment Depreciation
	a	b		
1	20 Actual (A)			
2	20 (A)			
3	20 (A)			
4	20 (P1)			
5	20 (P1)			
6	20 (P1)			
7	20 (P1)			
8	20 (P2)			
9	20 (P2)			
10	20 (P2)			
11	20 (P2)			
12				
13				
14	20 Actual (A)			
15	20 (A)			
16	20 (A)			
17	20 (P1)			
18	20 (P1)			
19	20 (P1)			
20	20 (P1)			
21	20 (P2)			
22	20 (P2)			
23	20 (P2)			
24	20 (P2)			
25				
26				
27	20 Actual (A)			
28	20 (A)			
29	20 (A)			
30	20 (P1)			
31	20 (P1)			
32	20 (P1)			
33	20 (P1)			
34	20 (P2)			
35	20 (P2)			
36	20 (P2)			
37	20 (P2)			
38				

<sup>a</sup> On this line state the name of the cost center (Column 1)

<sup>b</sup> On this line indicate the standard unit of measure (column 2) and number of units for Actual, P<sub>1</sub> and P<sub>2</sub>

Note: Use copies of this sheet for additional cost centers



## Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

(5)			(6)	(7)	(8)	(9)	
	Cost Center		Physician Compensation & Benefits*	Direct Expenses Excluding Physician Compensation & Benefits & MME Depreciation	Total Direct Expenses (Cols. 4+5+6)	Allocated Expenses	Total Expenses (Cols. 7+8)
	a						
1	20	Actual (A)					
2	20	(A)					
3	20	(A)					
4	20	(P1)					
5	20	(P1)					
6	20	(P1)					
7	20	(P1)					
8	20	(P2)					
9	20	(P2)					
10	20	(P2)					
11	20	(P2)					
12							
13							
14	20	Actual (A)					
15	20	(A)					
16	20	(A)					
17	20	(P1)					
18	20	(P1)					
19	20	(P1)					
20	20	(P1)					
21	20	(P2)					
22	20	(P2)					
23	20	(P2)					
24	20	(P2)					
25							
26							
27	20	Actual (A)					
28	20	(A)					
29	20	(A)					
30	20	(P1)					
31	20	(P1)					
32	20	(P1)					
33	20	(P1)					
34	20	(P2)					
35	20	(P2)					
36	20	(P2)					
37	20	(P2)					
38							

\* Include in this column fringe benefits.

Note: The difference between P<sub>1</sub> and P<sub>2</sub> Schedule A, Line 19 "Total Operating Expenses" must tie to the difference between P<sub>1</sub> and P<sub>2</sub> "Schedule B, Column 9, "Total Expenses"

## Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

	(10)	(11)	(12)	(13)
	Cost Center	Standard Unit of Measure	Gross Patient Service Revenue	Major Movable Equipment Depreciation
	a	b		
1	20 Actual (A)			
2	20 (A)			
3	20 (A)			
4	20 (P1)			
5	20 (P1)			
6	20 (P1)			
7	20 (P1)			
8	20 (P2)			
9	20 (P2)			
10	20 (P2)			
11	20 (P2)			
12				
13	Other Revenue Producing Cost Centers			
14	20 Actual (A)			
15	20 (A)			
16	20 (A)			
17	20 (P1)			
18	20 (P1)			
19	20 (P1)			
20	20 (P1)			
21	20 (P2)			
22	20 (P2)			
23	20 (P2)			
24	20 (P2)			
25				
26	Total Revenue Producing Cost Centers			
27	20 Actual (A)			
28	20 (A)			
29	20 (A)			
30	20 (P1)			
31	20 (P1)			
32	20 (P1)			
33	20 (P1)			
34	20 (P2)			
35	20 (P2)			
36	20 (P2)			
37	20 (P2)			
38				
39				
40				

<sup>a</sup> On this line state the name of the cost center, Column 10.

<sup>b</sup> On this line indicate the standard unit of measure, Column 11, and number of units for Actual, P<sub>1</sub> and P<sub>2</sub>

## Schedule C: Staffing Patterns

Complete in detail the staffing level of the service(s) that will be affected by the proposed project.

(1)		(2)	(3)	(4)
		Number of FTEs*		
		20 <sup>a</sup> Actual Year	20 <sup>b</sup> P1 Year	20 <sup>b</sup> P2 Year
1	Service (specify):			
2	Personnel category			
3				
4				
5				
6				
7				
8	Service (specify):			
9	Personnel category			
10				
11				
12				
13				
14				
15	Service (specify):			
16	Personnel category			
17				
18				
19				
20				
21				
22	Service (specify):			
23	Personnel category			
24				
25				
26				
27				
28				
29	Service (specify):			
30	Personnel category			
31				
32				
33				
34				
35				
36	Service (specify):			
37	Personnel category			
38				
39				
40				
41				
42				
43	All Personnel			

\*A FTE is a full-time equivalent employee. See the *Hospital Uniform Reporting Manual* for the computation of full-time equivalent.

<sup>a</sup> For the fiscal year most recently completed.

<sup>b</sup> The year when normal operating volume is achieved.

## Schedule D: Estimated Capital Expenditure

Outlined below is a comprehensive list of all components of Estimated Capital Expenditures. Capital Expenditure as defined in the Regulations includes the site acquisition cost of land and buildings or **fair market value of land and buildings if leased (capital or operating) or donated**, the total cost of construction including all site improvements, the cost of all capital equipment or **fair market value if leased (capital or operating) or donated**, the cost of all professional fees associated with the development of the project, including fees for architectural, engineering, legal, accounting, feasibility, planning and financing services, any fee associated with financing including any bond discount, and the interest cost to be incurred on funds borrowed during construction (but not including the on-going interest expense of permanent financing).

The estimate to be computed below must be based on costs and interest rates, which assume commencement and/or implementation of the project as of the date of application; therefore, the estimate should *not* include inflation up to the *anticipated actual* commencement and/or implementation date. (Where appropriate, an inflationary allowance is applied later during the DoN Staff's monitoring of the approved project.)

Because the inflation allowance is an important factor in large, costly construction projects, prospective applicants for such projects should consult the DoN Office for technical advice regarding completion of Schedule D. Do not include a special provision for contingency.

	(1) Category of Expenditure	(2) New Construction	(3) Renovation
1	Land Costs:	\$	\$
2	Land Acquisition Cost		
3	Site Survey and Soil Investigation		
4	Other Non-Depreciable Land Development <sup>a</sup>		
5	Total Land Costs (Lines 2 through 4)		
6	Construction Costs:		
7	Depreciable Land Development Cost <sup>b</sup>		
8	Building Acquisition Cost		
9	Construction Contract (including bonding cost)		
10	Fixed Equipment Not in Contract		
11	Architectural Cost (including fee, printing, supervision etc.) and Engineering Cost		
12	Pre-filing Planning and Development Costs		
13	Post-filing Planning and Development Costs		
14	Other (specify):		
15	Other (specify):		
16	Net Interest Expense During Construction <sup>c</sup>		
17	Major Movable Equipment <sup>d</sup>		
18	Total Construction Costs (Lines 7 through 17)		
19	Financing Costs:		
20	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc.)		
21	Bond Discount		
22	Other (specify):		
23	Total Financing Costs (Lines 20 through 22)		
24	Estimated Total Capital Expenditure (Line 5 + Line 18 + Line 23)		

### Footnotes:

- Examples of Other Non-Depreciable Land Development Costs:* commissions to agents for purchase of land, attorney fees related to land, demolition of old buildings, clearing and grading, streets, removal of ledge, off-site sewer and water lines, public utility charges necessary to service the land, zoning requirements, and toxic waste removal.
- Examples of Depreciable Land Development Costs:* construction of parking lots, walkways and walls; on-site septic systems; on-site water and sewer lines; and reasonable and necessary landscaping.
- Describe assumptions used in calculating interest rates and costs.*
- Acute care hospitals need not include equipment expenditure unless for DoN regulated device (see 105 CMR 100.022, definition of Expenditure Minimum).*

## Schedule E: Depreciation Expense

Complete for project's estimated capital expenditure (including the fair market value for capital lease), which will be depreciated. For a given category and cost center show in aggregate the data for assets with the same useful lives. Include in the basis the asset's appropriate share of construction interest and professional fees. Use the estimates from Schedule D.

	(1)	(2)	(3)	(4)
	Description of Asset	Basis for Depreciation	Useful Life	Annual Depreciation Expense
1	Building:			
2				
3				
4				
5				
6				
7	Land Improvements:			
8				
9				
10				
11				
12				
13	Building Improvements:			
14				
15				
16				
17				
18				
19	Parking Facilities:			
20				
21				
22				
23				
24				
25	Fixed Equipment:			
26				
27				
28				
29				
30				
31	Major Movable Equipment:			
32				
33				
34				
35				
36				
37	Total			

Note: For simplicity assume first year of depreciation is a full year depreciation not one half year of depreciation. Also, if project is to be gradually phased in do not adjust for such phasing unless it significantly affects this Schedule. Explain such adjustments.

## Schedule F: Proposed Funds for Estimated Capital Expenditure

Show only those funds, which are intended to finance the estimated capital expenditure.

	(1)	(2)
	<b>Funds Available as of Application Filing Date:</b>	
1	Plant Replacement and Expansion Fund	\$
2	Unrestricted Fund	
3	Endowment Fund	
4	Specific Purpose Fund	
5	Other (specify):	
6	Subtotal	
	<b>Funds to be Generated/Raised:</b>	
	Internal Sources:	
7	Accumulated Gain from Operations	
8	Accumulated Non-operating Revenue <sup>a</sup>	
	External Sources:	
9	Long Term Debt Proceeds <sup>b</sup> (available _____ / _____) <sup>c</sup> month year	
10	Grants (available _____ / _____) month year	
11	Unrestricted Gifts/ Bequests (available _____ / _____) month year	
12	Plant Fund Drive (available _____ / _____) month year	
13	Capital Lease (terms) _____ / _____ rate years	
14	Subtotal	
15	<b>Total Funds</b> (Line 6 - Line 13)	\$

<sup>a</sup> Exclude unrestricted gifts and bequests. Show these on Line 11.

<sup>b</sup> Complete Schedule F1.

<sup>c</sup> Provide date when total amount will be available.

## Schedule F1: Features of Permanent Financing of Estimated Capital Expenditure <sup>a</sup>

- 
1. a) Loan principal\_\_\_\_\_b) Interest rate\_\_\_\_\_c) Term\_\_\_\_\_yrs.
  2. Does the proposed debt service require even periodic payments, which include interest and principal?  
☐ Yes ☐ No  

If *No*, attach a separate sheet outlining the required schedule of payments of interest and principal over the term of the loan.
  3. Check anticipated source of permanent financing.<sup>b</sup>  
☐ Lending Institution (specify)\_\_\_\_\_  
☐ Massachusetts Health and Educational Facilities Authority  
☐ Federal Housing and Urban Development Administration Insured Mortgage  
☐ Public or Private Sale Bonds  
☐ Other (specify) \_\_\_\_\_
  4. Check anticipated debt instrument.  
☐ Mortgage  
☐ Mortgage Bonds  
☐ Notes  
☐ Taxable Bonds  
☐ Tax-exempt Bonds  
☐ Bond Anticipation Note  
☐ Other (specify) \_\_\_\_\_
  5. Specify the loan covenants (such as required sinking fund payments, and compensating balances) associated with the proposed financing.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  6. Indicate specific extent of mortgagee's proposed collateral interest in real property, gross receipts, etc.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  7. Will the proposed long term loan refinance a construction loan? ☐ Yes ☐ No
  8. If Yes, complete the following:  
 a) Source of construction loan\_\_\_\_\_  
 b) Maximum principal outstanding\_\_\_\_\_  
 c) Terms of interest rate\_\_\_\_\_
  9. Anticipated date for the delivery of the long-term loan proceeds\_\_\_\_\_

<sup>a</sup> If appropriate complete for internal as well as external loans.

<sup>b</sup> If uncertain, use "1", "2", etc. to indicate order of likelihood. Explain effect on cost in going from source number 1 to source number 2, etc.

Complete question 8 only if the project includes refinancing of existing debt

## Schedule F2: Application of Permanent Financing Proceeds

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Complete only for the estimated capital expenditures of projects requiring debt financing.

	(1)	(2)
1	Total Estimated Land and Construction Costs (from Schedule D, Columns 2 and 3, Line 5 + Line 18)	\$
2	Debt Service Fund Requirement	
3	Total Financing Costs (from Schedule D, Columns 2 and 3, Line 23)	
4	Refinancing of Existing Debt	
5	Other (specify):	
6	Other (specify):	
7	Subtotal	
8	Less:	
9	Project Costs met by Internal Sources (from Schedule F, Column 2, Lines 6 + 7 + 8)	
10	Interest Income Earned During Construction	
11	Premium on Sale of Bonds	
12	Project Costs Met by External Sources Other than Debt (from Schedule F, Column 2, Lines 10 + 11 + 12)	
13	Total Deductions (Lines 9+10 + 11 + 12)	
14	Loan Principal Required (Line 7 - Line 13)	\$



## Schedule G: Fixed Charges Covered

Complete for the entire institution if the estimated capital expenditure for the project requires debt financing, including capital lease.

	(1)	(2)	(3)	(4)
		Actual <u>20</u>	Actual <u>20</u>	Actual <u>20</u>
1	Gain (Loss) from Operations <sup>a</sup>			
2	Add: Interest Expense <sup>a</sup>			
3	Depreciation Expense <sup>a</sup>			
4	Lease Payments			
5	Cash from Operations Available for Debt Service (Lines 1 + 2 + 3 + 4)			
6	Debt Service Required:			
7	Interest on Long Term Debt (LTD)			
8	Interest on Certain Short Term Debt <sup>b</sup>			
9	Principal Payments – LTD			
10	Reduction in Short Term Debt <sup>b</sup>			
11	Lease Payments			
12	Net Sinking Fund Payment <sup>c</sup>			
13	Total Debt Service Required (Lines 7 + 8 + 9 + 10 + 11 + 12)			
14	Ratio: Fixed Charges Covered (Line 5 ÷ Line 13)			

<sup>a</sup> Must tie to Schedule A data. Explain any variances.

<sup>b</sup> Include only short-term debt that will be rolled over or refinanced with long-term debt and any interest expense on inter-fund loans.

<sup>c</sup> Required payment to sinking fund less payment from sinking fund.

## Schedule G: Fixed Charges Covered

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Complete for the entire institution if the estimated capital expenditures for the project requires debt financing, including capital lease.

	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	Assuming Project Approval				Assuming Project Denial			
	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P2)	Projection 20____(P2)	Projection 20____(P2)	Projection 20____(P2)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								

## Schedule H: Revenue by Payer

Complete for the entire institution: Actual for the two fiscal years most recently completed and Projected (P1 and P2) for first full year of proposed project operation.

(1)		(2)	(3)	(4)
Payer		Total Patient Days	Routine Inpatient	
			Gross Patient Service Revenue	Net Patient Service Revenue
1	<b>20 Actual (A)</b>			
2	Medicare			
3	MA Medicaid			
4	Other Government			
5	Private Insurers			
6	Self Pay			
7	Other			
8	TOTAL			
9				
10				
11	<b>20 Actual (A)</b>			
12	Medicare			
13	MA Medicaid			
14	Other Government			
15	Private Insurers			
16	Self Pay			
17	Other			
18	TOTAL			
19				
20				
21	<b>20 Projected (P1)</b>			
22	Medicare			
23	MA Medicaid			
24	Other Government			
25	Private Insurers			
26	Self Pay			
27	Other			
28	TOTAL			
29				
30				
31	<b>20 Projected (P2)</b>			
32	Medicare			
33	MA Medicaid			
34	Other Government			
35	Private Insurers			
36	Self Pay			
37	Other			
38	TOTAL			
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				

## Factor 7    **RELATIVE MERIT**

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- 7.1    Please describe below and on additional sheet (if necessary) any alternatives that you have considered in the development of this project. Please also give your reasons for rejecting these alternatives.

## Factor 8 ENVIRONMENTAL IMPACT

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### I. Compliance with Massachusetts Environmental Protection Act (“MEPA”)

The MEPA (M. G.L. c. 30 §§ 61, 62-62H. 301 CMR 11.00 et seq.) program is an interdisciplinary program, which examines environmental impacts of state actions. Generally an entity seeking a state permit, approval or funding may be subject to MEPA review. The issuance of a Determination of Need is a state action subject to MEPA. MEPA regulations, which appear at 301 CMR 11.00, require environmental review of all DoN applications for projects exceeding the review thresholds set forth at 301 CMR 11.03. Applicants should fill out the attached checklist to determine whether MEPA review will be required.

Projects that are reviewed must circulate and file an Environmental Notification Form (ENF). A 20-day comment period ensues from publication of the ENF in the MEPA *Monitor* (appears bi-weekly). The proposal and site plans are reviewed, and within a total of 30 days from publication, a decision will be made on whether an environmental impact report (EIR) is required.

If an EIR is required, a “scope” will be issued, identifying issues, which the EIR must address. Draft and Final EIR’s each go through 37-day review and comment periods.

Certain projects, above specified size thresholds (301 CMR 11.03), require a mandatory EIR. The MEPA regulations allow the Secretary of Environmental Affairs to waive a mandatory EIR, or to allow a single EIR, following review of an expanded ENF. See 301 CMR 11.05(7), 11.06(8) and 11.11, and consult with the MEPA Office to discuss whether this approach would be appropriate.

Please address all inquiries to:

MEPA Office  
Executive Office of Energy and Environmental Affairs  
100 Cambridge Street, Suite 900, 9th Floor  
Boston, MA 02114  
Tel: (617) 626-9031

Please consult the MEPA office to determine if an Environmental Notification Form must be filed for the project. Please note that final approval of architectural plans and specifications for the project is contingent upon compliance with MEPA regulations.

### II. Compliance with Determination of Need Guidelines for Environmental and Human Health Impact

Effective January 1, 2009 for hospitals and clinics and July 1, 2009 for long term care facilities, all Determination of Need applications involving new construction and/or gut renovation projects are required to demonstrate compliance with the Determination of Need Guidelines for Environmental and Human Health Impact (“DoN Green Guidelines”). Gut renovation is defined as construction within an existing building that requires complete demolition of all non-structural building components (After demolition, only the floor, deck above, outside walls, and structural columns would remain). Compliance requires achievement of all of the prerequisites and at least 50% of all the possible points for the Leadership in Energy and Environmental Design – Health Care (“LEED-HC”) or, with the Department’s approval, its current equivalent nationally-accepted best practice standard.

Documentation of compliance with DoN Green Guidelines must be included in the submission of DoN Factor 8.

## Factor 8 ENVIRONMENTAL IMPACT: MEPA REVIEW THRESHOLDS

The following checklist summarizes the review thresholds in the state regulations, 301 CMR11.00, that are most likely to affect health care or long-term care project. The applicant must fill out every line in the checklist, relying upon its architect, engineers, or other technical consultants, as appropriate. For potential impacts upon rare species, the proponent should refer to the Natural Heritage Atlas and consult with the Natural Heritage and Endangered Species Program of the Division of Fisheries and Wildlife (1 Rabbit Hill Road, Westborough, MA 01581). Similarly, for potential impacts upon historic or archaeological resources, the proponent should refer to the State Register of Historic Places and the Inventory of Historical and Archaeological Resources of the Commonwealth and consult with the Massachusetts Historical Commission (220 Morrissey Boulevard, Boston, MA 02125). If the proponent is uncertain as to the requirement of MEPA review, one should refer to the full MEPA regulations and consult the MEPA Office (telephone: 617/626-1031). If necessary, the MEPA Office will issue a written advisory opinion as to whether MEPA review is required. A copy of the completed checklist should be enclosed with any request for an advisory opinion.

If any line of the checklist is answered "yes," MEPA review of the project will be required. Refer to the MEPA regulations and consult with the MEPA Office for the requirements governing the filing of an Environmental Notification Form.

Threshold		Yes	No
<i>Land</i>	Direct alteration of 25 or more acres of land.		
	2. Creation of five or more acres of impervious area.		
	3. Conversion of land held for natural resources purposes in accordance with Article 97 of the Massachusetts Constitution to any purpose not in accordance with Article 97.		
	4. Conversion of land in active agricultural use to non-agricultural use, provided the land includes soils classified as prime, state-important or unique by the United States Department of Agriculture.		
	5. Release of an interest in land held for conservation, preservation or agricultural or watershed preservation purposes.		
	6. Approval in accordance with M.G.L. c.121B of a New urban renewal plan or a major modification of an existing urban renewal plan.		
<i>Rare Species</i>	1. Alteration of designated significant habitat.		
	2. Taking of an endangered or threatened species of a special concern, provided that the Project site is two or more acres and includes an area mapped as a Priority Site of Rare Species Habitats and Exemplary Natural Communities.		
<i>Wetlands, Waterways and Tidelands</i>	1. Provided that a Permit is required, alteration of 5000 or more sf of bordering or isolated vegetated wetlands;		
	2. Provided that a Permit is required, new fill or structure or Expansion of existing fill or structure, except a pile-supported structure, in a velocity zone or regulatory floodway.		
	3. Provided that a Permit is required, alteration of ½ or more acres of any other wetlands.		
	4. Provided that a Chapter 91 license is required, New or existing non-water dependent use of waterways or tidelands.		
<i>Water</i>	1. New withdrawal or Expansion in withdrawal of 100,000 or more gpd from a water source that requires New construction for the withdrawal.		
	2. Alteration requiring a variance in accordance with the Watershed Protection Act.		

<i>Transportation</i>	1. Construction, widening or maintenance of a roadway or its right-of-way that will: a. alter the bank or terrain located ten or more feet from the existing roadway for one-half or more miles, unless necessary to install a structure or equipment; b. cut five or more living public shade trees of 14 or more inches in diameter at breast height; or c. eliminate 300 or more feet of stone wall		
	2. Abandonment of a substantially intact rail or rapid transit right-of-way.		
	3. Generation of 2,000 or more New adt on roadways providing access to a single location.		
	4. Generation of 1,000 or more New adt on roadways providing access to a single location and construction of 150 or more New parking spaces at a single location.		
	5. Construction of 300 or more New parking spaces at a single location.		
<i>Historical And Archaeological Resources</i>	1. Unless a Project is subject to a Determination of Need Adverse Effect by the Massachusetts Historical Commission or is consistent with a Memorandum of Agreement with the Massachusetts Historical Commission that has been the subject of public notice and comment: a. demolition of all or any exterior part of any Historic Structure listed in or located in any Historic District listed in the State Register of Historic Places or the Inventory of Historic and Archaeological Assets of the Commonwealth; or b. destruction of all or any part of any Archaeological Site listed in the State Register of Historic Places or the Inventory of Historic and Archaeological Assets of the Commonwealth.		
<i>ACECs</i>	1. Any Project within a designated ACEC		

Name of Project: \_\_\_\_\_

Name of Proponent: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Factor 8 ENVIRONMENTAL IMPACT: DoN GREEN GUIDELINES**

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In this section, provide complete documentation of how the project, upon its implementation, will achieve compliance with the Determination of Need Guidelines for Environmental and Human Health Impact ("DoN Green Guidelines"). A completed project scorecard based upon the most current version of LEED-HC or its equivalent, as approved by the DoN Program prior to application submission, should accompany a description of the plans for compliance.



## FACTOR 9 COMMUNITY HEALTH SERVICE INITIATIVES

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For detailed information regarding completion of DoN Factor 9, applicants should consult the Community Health Initiatives Policies and Procedures (Revised August 19, 2014) at [www.mass.gov/dph/don](http://www.mass.gov/dph/don).

The Determination of Need primary and preventive health care services and community contributions review factor is required under 105 CMR 100.533(B)(9) and described under 105 CMR 100.551(J) as follows:

- (1) the holder [of an approved DoN] shall expend, over a five-year period (or other period approved by the Department) an amount reasonably related to the cost of the project, for the provision of primary and preventive health care services necessary for underserved populations in the project's service area (or other area approved by the Department) and reasonably related to the project, in accordance with a plan submitted as part of the application process (see 105 CMR 100.533(B)(9)) and approved by the Department; and
  - (2) the holder shall file reports with the Department detailing compliance with its approved plan, and to the extent practicable, an evaluation of the health effects thereof. The frequency, content and format of such reports shall be established by the Department.
- 1.1 The plan for provision of primary and preventive health services shall be developed in consultation with the Community Health Network Areas (CHNAs) and Department of Public Health's Office of Community Health Planning to identify health issues in the service areas and the community initiatives that should be directed toward them. To identify the CHNAs in your service areas please contact the [Office of Community Health Planning](#).